STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 00 B. WING	07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure Survey. Survey Dates: 7/8-7/12/12 Facility number: 000544 Provider number: 155673 AIM number:: 100267340 Survey Team: Shelley Reed RN TC Julie Call RN Linn Mackey RN Virginia Terveer RN Census Bed Type: SNF/NF 78 Total: 78 Census Payor Type: Medicare: 7 Medicaid: 51 Other: 20 Total: 78 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/19/12 Cathy Emswiller RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 1 of 14 interviewed residents reviewed for physical abuse in a sample of 40. (Resident #98) Findings include: In an interview with Resident #98 on 7-9-2012 at 11:06 A.M., the Resident indicated staff wanted to get the Resident up to sit in the chair. The Resident refused due to previously being left in the chair for a 3 hour period. Resident #98 indicated the staff moved the Resident roughly to the chair. Resident #98 was unable to identify the staff member or when the incident occurred. The Resident indicated the incident was not reported and wanted the Administrator notified. The Administrator was notified of the	F0223	F223It is the practice of this facility to ensure each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, & involuntary seclusion. It is also the practice of this facility to ensure verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion is not used.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility management immediately suspended an employee, pending further investigation of the allegation. Upon completion of a thorough investigation, the allegation was determined to be unsubstantiated and the employee was permitted to return to work. Upon conclusion of the investigation, facility management submitted a Follow-Up Report to ISDH on 7-13-12. II. How will other residents having the potential to be affected by the same deficient practice be identified & what	08/11/2012

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	incident in an interview on 7-9-2012 at 11:29 A. M. Resident #98's clinical record was reviewed on 7-10-2012 at 3:17 P.M. Resident #98's diagnoses included but are not limited to meningioma, hypertension, anemia, hyperlipidemia, dyspnea, fatigue, seizure disorder, insomnia, gastrointestinal reflux disease, COPD (chronic obstructive pulmonary disease, CHF (congestive heart failure), depression, coronary artery disease, weight loss. Resident #98 scored a 15 of 15 for the brief interview mental status (BIMS) on the Minimum Data Set assessment (MDS) dated 5-9-2012, 6-19-2012 and 6-24-2012. On 7-11-2012 at 12:00 P.M., a review of an abuse investigation report indicated the report was initiated on 7-9-12 after rough treatment to Resident #98 was reported to administrator. A copy of the e-mail subject page indicated the initial report was transmitted to ISDH (Indiana State Department of Health) on 7-9-2012 at 2:35 P.M., and faxed to APS (Adult Protective Services) on 7-9-2012 at		corrective action(s) will be taken: Employees were re-educated on abuse & neglect policy. The all-staff inservice will be conducted by DNS/designee & completed by 8-11-12.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Members of the IDT team will conduct resident interviews using the questions in section G (Abuse) listed on the CMS form titled Resident Interview & Resident Observation. Interviews will be conducted on all "interviewable" residents by 8-11-12. Any negative findings will be immediately reported to the facility Administrator/DNS & investigated. During the monthly resident council meetings, the Administrator or another invited IDT member will encourage residents to voice any concerns they may have regarding abuse, mistreatment, or misappropriation. IDT members will be responsible to conduct monthly Family Interviews. At the time of each interview, the IDT member will complete the CMS form titled Family Interview. Family interviews will be conducted in conjunction with our already established Customer Care program & are done monthly.IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality	

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	1:48 P.M., and faxed to the Ombudsman on 7-9-12 at 8:34 P.M. The facility followed it's policy and procedure for the investigation of physical abuse, which included but was not limited to: a) The Administrator and Social Service Director interviewed the resident. b) A full body assessment was completed on Resident #98 and no injuries were noted. c) The son was notified of the rough treatment allegation on 7-10-12 at 2:22 P.M. d) The physician was notified. e) Twenty resident interviews were conducted using the QIS (Quality Indicator Survey) abuse tool on alert and oriented residents. f) Sixteen current facility personnel were interviewed. Review of a current facility policy and procedure dated February 2010 titled "Abuse Prohibition, Reporting and Investigation" which was provided by		assurance program will be put into place: DNS/designee will be responsible for completion of the CQI tool titled "Resident Interview". The audit tool will be completed weekly x 4 weeks, then monthly x 6 months. Trends or findings will be submitted to the CQI committee for review & follow-up.V. By what date will systemic changes be completed: 8-11-12	

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	the Administrator on 7-11-2012 at 12:36 P.M., indicated the following: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." 3.1-27(a)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on interview and record review, the facility failed to ensure the staff treated residents with respect and dignity in 1 of 14 resident interviews for respect and dignity in a sample of 40. (Resident #98) Findings include: During an interview with Resident #98 on 7-9-2012 at 11:06 A.M., the Resident indicated not being treated with respect and dignity. The Resident indicated staff wanted to get the Resident up to sit in the chair and the Resident refused due to previously being left in the chair for a 3 hour period. Resident #98 indicated the move to the chair was done roughly by staff. Resident #98 was unable to identify the staff member or when the incident occurred. The Resident indicated the incident was not reported and wanted the Administrator notified.	F0241	F241It is the practice of this facility to promote care for residents in a manner & in an environment that maintains or enhances each resident's dignity & respect in full recognition of his or her individuality. I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility management immediately suspended an employee, pending further investigation of the allegation. Upon completion of a thorough investigation, the allegation was determined to be unsubstantiated & the employee was permitted to return to work. Upon conclusion of the investigation, facility management submitted a Follow-up Report to ISDH on 7-13-12. II. How will other residents having the potential to be affected by the same deficient practice be identified & what corrective action(s) will be taken: Employees were re-educated on Resident Rights. The inservice will be completed by 8-11-12 & conducted by DNS/designee.III. What measures will be put into place or	08/11/2012

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	The Administrator was notified of the incident in an interview on 7-9-2012 at 11:29 A. M. Resident #98's clinical record was reviewed on 7-10-2012 at 3:17 P.M. Resident #98's diagnoses included but are not limited to meningioma, hypertension, anemia, hyperlipidemia, dyspnea, fatigue, seizure disorder, insomnia, gastrointestinal reflux disease, COPD (chronic obstructive pulmonary disease, CHF (congestive heart failure), depression, coronary artery disease, weight loss. Resident #98 scored a 15 of 15 for the brief interview mental status (BIMS) on the Minimum Data Set assessment (MDS) dated 5-9-2012, 6-19-2012 and 6-24-12. 3.1-3(t)		what systemic changes will be made to ensure that the deficient practice does not recur: Members of the IDT team will conduct resident interviews using the question in section C (Dignity) listed on the CMS form titled Resident Interviw & Resident Observation. Interviews will be conducted on all "interviewable" residents by 8-11-12. Any negative findings will be immediately reported to the facility Administrator/DNS & investigated. During the monthly resident council meetings, the Administrator or another invited IDT member will encourage residents to voice any concerns they may have regarding abuse, mistreatment, or misappropriation. IDT members will be responsible to conduct monthly Family Interviews. At the time of each interview, the IDT member will encourage residents to voice any concerns they may have regarding abuse, mistreatment, or misappropriation. Family interviews will be conducted in conjunction with our already established Customer Care program & will be done monthly.IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DNS/designee will be responsible for completion of the CQI tool titled "Resident	

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			Interview". The audit tool will be completed weekly x 4 weeks, then monthly x 6 months. Trends or findings will be submitted to the CQI committee for review & follow-up.V. By what date will the systemic changes be completed: 8-11-12.	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to provide dental care for 1 of 3 residents reviewed for dental status and services in a sample of 14. (Resident # 7) Findings include: Resident # 7's clinical record was reviewed on 7/10/12 at 2:43 p.m. Resident # 7's diagnoses included, but were not limited to cerebral vascular accident (stroke), arthritis, Parkinson's disease. Resident # 7 had a current, 5/25/12 Minimum Data Set assessment which indicated a BIMS (brief interview of mental status) of 15, a score of 13 to 15 indicates that the resident is cognitively intact. The MDS also reflects that the resident needs extensive assistance with personal hygiene. Resident # 7's care plan with a review date of 6/05/12 which indicated, the	F0282	F282It is the practice of this facility to provide for or arrange for services provided by qualified persons in accordance with each resident's written plan of care.I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The affected resident is offered dental care twice daily.Resident's C.N.A. sheet was updated to reflect that resident is to be offered dental care twice daily.II. How are other residents having the potential to be affected by the same deficient practice identified & what corrective action(s) will be taken: Nursing staff were inserviced on dental care. The inservice will be conducted by DNS/designee & completed by 8-11-12.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: C.N.A. assignment sheets have been updated to indicate those residents who need dental care. C.N.A.s are now required to document provision of dental care twice daily. Documentation will also include any resident refusals. A list of residents who	08/11/2012

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	resident will have her teeth brushed 2 times a day. During an interview, on 7/9/12 at 2:46 p.m. with Resident 7, she indicated her teeth were brushed twice a week. During an observation, on 7/8/12 at 5: 00 p.m., Resident # 7 was in the dining room awaiting supper. Her teeth had white material at the gum line. During an observation, on 7/9/12 at 1:46 p.m., Resident # 7's teeth had white material at the gum line and gums were red and swollen. During an observation and interview, on 7/10/12 at 2:00 p.m. Resident # 7 indicated she had not had her teeth brushed today. The resident's teeth were discolored and her gums were red and swollen. During an observation, on 7/10/12 at 1:46 p.m., Resident # 7's teeth had a white substance at the gum line and the gums were red and swollen. During an interview, on 7/12/12 at 8:00 a.m., Resident # 7 indicated her teeth were not brushed this morning. Her tooth brush on the bed side stand appeared dry and the 2		are to receive mouth care will be provided to the charge nurse on each hall. The charge nurse will verify that proper oral care has been provided & document on a log. The completed log will be turned into the DNS weekly for review & any needed follow-up. IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DNS/designee will be responsible for completion of the CQI audit tool titled "Dental Services". This audit tool will be completed weekly x 4 weeks, then monthly x 6 months. Trends or findings will be submitted to the CQI committee for review & follow-up.V. By what date will the systemic changes be completed: 8-11-12	

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	other toothbrushes in her drawer also appeared to be dry. During an interview, on 7/12/12 at 10: 35 a.m., The Administrator indicated the facility did not have a policy for a.m. and p.m. care. The facility used the skills check off for CNA (Certified Nurse Assistant) which indicated the residents should get assistance with oral hygiene in the a.m. and in the p.m. 3.1-35(g)(1)			

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F0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food was served at a palatable temperature for 4 of 14 residents interviewed with the potential to affect 17 residents receiving delivered meal trays in their rooms and 25 residents receiving meal trays delivered to "The Cottage" (Memory Care Unit). (Resident # 62, 78, 87, 98) Findings include: 1. During resident interviews conducted on 7/9/12 and 7/10/12, 4 of 14 residents interviewed indicated food items were not served at proper temperatures. (Residents # 62, 78, 87, 98) Interview with Resident # 87 on 7/9/12 at 9:23 a.m. indicated the hot food is not hot, bacon is cold, and even the soup is cold. Interview with Resident # 62 on 7/9/12 at 10:31 a.m. indicated the food is occasionally warm.	F0364	F364It is the practice of this facility to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and to serve food that is palatable, attractive, and at the proper temperature.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Dietary manager/designee is testing the food for proper temps. The frequency of taking food temps has been increased to 1. at the beginning of trayline service, 2. just prior to the food cart leaving the kitchen, and 3. after the last meal of the delivery cart has been served. Dietary manager/designee is recording these temps on a log.II. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken. Facility dietician will inservice dietary staff regarding the requirement to serve food at the proper food temps. Inservice will be completed by 8-11-12. III. What	08/11/2012

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	Interview with Resident # 98 on 7/9/12 at 11:15 a.m. indicated the food is cold. Interview with Resident # 78 on 7/9/12 at 4:32 p.m. indicated the food is usually cold, by the time it get to us in The Cottage. 2. During observation of meal tray preparation on 7/10/12 at 11:00 a.m., it took 25 minutes to complete 25 trays for The Cottages. The Cambro Cart (food cart) left kitchen at 11:30 a.m. to be delivered to The Cottage, 30 minutes after first lunch tray was place on plate and stored in delivery cart. 3. During observation of meal tray preparation for The Cottage on 7/11/12 at 11:00 a.m., it took 20 minutes to complete 25 meal trays. At 11:23 a.m. observed the Dietary Manager #1 pulled out the first meal tray completed and stored in the Cambro to measure food temperatures. The Dietary Manager's thermometer indicated the following food temperatures: grilled chicken pasta salad, chicken breast strips was 89 degrees, lettuce and pasta was 75 degrees, dices pears was 44.1 degrees, milk was 51.1 degrees, and the apple juice was 52.9		measurees will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Cold food items & cold beverages will be kept refrigerated until immediately before the doors are closed on the food delivery carts. The cold items/cold beverages will be the last items placed on each tray. This will enable the cold items to be served at the proper cold temperature. Fluids will be provided for the Cottage resident meals in pitchers & Cottage staff will pour their own drinks. The pitchers will be filled & delivered by dietary personnel/designee to the Cottage prior to meal service and stored in the Cottage refrigerator until meal time. Dietary manager will ensure that each hot food item is put on a plate that has been thoroughly heated & will immediately cover the food in order to properly retain the hot temperature. The Dietary manager will reorganize our tray line service procedure in order to speed up the efficiency of meal service. RD will audit/evaluate this procedure on her regular facility visits. The dining room managers/designee will be responsible for completion of the Food Quality Evaluation form for each meal. Completed form will be submitted to the ED/designee for review & necessary follow-up. Dietary Manager/designee will be responsible to conduct a	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	degrees. 4. On 7/12/12 at 12:15 p.m., during dining room observation of temperature checks with the Dietary Manager #1, the Dietary Manager ' s thermometer indicated the following temperatures: diced pears 49.6 degrees, milk 41.7 degrees and chicken Caesar salad with pasta 65 degrees. 5. Review of a current facility policy dated, 04/11 titled " Food Temperatures " which was provided by the Dietary Manager on 7/11/12 at 12:30 p.m., indicating the following: "Hot foods that are potentially hazardous will leave the kitchen (or steam table) above 135 degrees and cold food at or below 41 degrees." 3.1-21(a)(2)		minimum of 10 randomly selected resident interviews using the questions in section QP249 (Food Quality) listed on the CMS form titled Resident Interview & Resident Observation. Interviews will be completed monthly x 6 months. Any negative findings will be promptly addressed & reported to facility administrator. IV. Dietary Manager/designee will be responsible for completion of a CQI tool titled "Meal Service". The audit tool will be completed weekly x 4 weeks, then monthly x 6 months.V. By what date will the systemic changes be completed: 8-11-12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 00 B. WING	07/12/2012

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F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure an insulin pen was properly labeled with date opened for 1 of 1 insulin	F0431	F431It is the practice of this facility to employ or obtain the services of a licensed pharmacist who establishes a system or records of receipt and disposition	08/11/2012

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	pens reviewed stored in 1 of 3 medication carts. The facility also failed to properly dispose of an expired bottle of medication stored in 1 of 3 medication carts reviewed. Findings include: On 7/12/12 at 9:47 a.m., during a medication storage tour with the DoN, while observing medication storage, the medication cart in the 200 hall was found to have a bottle of Hydrocodone (medication used to treat pain) containing 2 ½ tablets that expired on 5/31/12. On 7/12/12 at 9:50 a.m., the medication cart on the 300 hall was found to have a Lantus SoloStar insulin pen (medication used to lower blood sugar) with no date on the pen when first opened. Interview on 7/12/12 at 11:37 a.m., the DoN indicated the representative from the contracted pharmacy was in the facility 6/19/12 to review medications. The DoN indicated the medication should be dated when opened and should be disposed when expired. During an interview on 7/12/12 at 2:50 p.m., the ADON indicated the Lantus insulin pen was almost full and just opened 2 days prior to the medication		of all controlled drugs in sufficient detail to enable an accurate reconciliation; and to determine that drug records are in order and that an account of all controlled drugs is maintained & periodically reconciled.It is the practice of this facility to ensure that drugs & biologicals used in the facility are labeled in accordance with currently accepted professional principles & include the appropriate accessory & cautionary instructions, and the expiration date when applicable.It is the practice of this facility to ensure, in accordance with State & Federal laws, that the facility stores all drugs & biologicals in locked compartments under proper temperature controls, & permit only authorized personnel to have access to the keys.It is the practice of this facility to provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The insulin pen was destroyed. The expired	

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	storage observation by an RN who was currently off. She indicated the Hydrocodone was discontinued before the expiration date on the bottle according to physician orders and the resident did not receive any additional doses of medication. 3.1-25(o) 3.1-25(e)(3)		medication was destroyed on 7-12-12.II. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: Licensed nurses will be re-educated on proper medication storage (i.e. dating medications when opened and discarding expired medications). Inservice will be conducted by DNS/designee & completed by 8-11-12.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A llicensed nurse on each hallway will audit their med cart for expired meds & improperly labeled meds at the end of each shift & document the review on a log. The completed log will be turned into the DNS for review & follow-up.IV. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:DNS/designee will be responsible for completion of the CQI tool titled "Medication Storage Review". The audit tool will be completed monthly x 6 months. Trends or findings will be submitted to the CQI committee for review & follow-up.V. By what date will the systemic changes be completed: 8-11-12.	